

Physician Report for Elevated Blood Lead Levels



Arizona Administrative Code R9-4-301 Requires:

Children <16 years of age:

All blood lead levels of \$10 ug/dL are reportable within 5 working days from the date of receipt of the laboratory results. Blood lead levels \$45 ug/dL are reportable within 1 business day.

Adults \$16 years of age:

All blood lead levels of \$25 ug/dL are reportable within 5 working days from the date of receipt of the laboratory results. Blood lead levels of \$60 ug/dL are reportable within 1 business day.

CONFIDENTIAL

LEAD POISONING PREVENTION PROGRAM

ARIZONA DEPARTMENT OF HEALTH SERVICES

150 N. 18TH Avenue, Suite# 430

PHOENIX, ARIZONA 85007

602- 364-3118 1-800-367-6412 FAX 602-364-3146

PLEASE SUBMIT REPORT BY PHONE, MAIL OR FAX. IF FAXED, PLEASE CALL AHEAD TO ENSURE CONFIDENTIALITY.

PATIENT LAST NAME		FIRST NAME		FOR ADHS USE: DATE RECEIVED _____ ID# _____ <input type="checkbox"/> SCREEN <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> FOLLOW-UP CONFIRMED? <input type="checkbox"/> YES <input type="checkbox"/> NO INVESTIGATION <input type="checkbox"/> YES <input type="checkbox"/> NO FAMILY CONTACTED <input type="checkbox"/> YES <input type="checkbox"/> NO DATE CASE CLOSED _____
DATE OF BIRTH		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
STREET ADDRESS				
MAILING ADDRESS				
CITY	COUNTY	ZIP CODE		HOME PHONE () MESSAGE PHONE ()
HEALTH PLAN	ID#			
<input type="checkbox"/> AHCCCS <input type="checkbox"/> KIDS CARE <input type="checkbox"/> INDIAN HEALTH SERVICES <input type="checkbox"/> TOBACCO TAX <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> SELF PAY <input type="checkbox"/> OCCUPATIONAL MONITORING	RACE* <input type="checkbox"/> WHITE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> OTHER		ETHNICITY* <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> UNKNOWN	
PARENT OR GUARDIAN NAME*		LANGUAGE* <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER		
ADULTS: EMPLOYER'S BUSINESS NAME:			OCCUPATION	
EMPLOYER ADDRESS:			EMPLOYER PHONE ()	
BLOOD LEAD LEVEL: <i>ug/dL</i>	DATE COLLECTED:	DATE RESULT REPORTED FROM LABORATORY:	<input type="checkbox"/> VENOUS <input type="checkbox"/> UNKNOWN <input type="checkbox"/> CAPILLARY	
LABORATORY	ADDRESS		PHONE	
PHYSICIAN LAST NAME		PHYSICIAN FIRST NAME		
PRACTICE OR CLINIC		ADDRESS		
CITY	STATE	ZIP	PHONE	
COMMENTS:				
PLEASE SEND WHITE COPY TO THE ADHS. RETAIN THE YELLOW COPY FOR YOUR FILES. *THIS INFORMATION IS HELPFUL FOR CASE MANAGEMENT PURPOSES, ALTHOUGH NOT REQUIRED BY LAW				